SECTION 2

UTAH HOME AND COMMUNITY - BASED WAIVER SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES AND MENTAL RETARDATION

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1 GENERAL POLICY

Under Section 1915(c) of the Social Security Act, a State may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to "waive" certain statutory requirements in order to use Medicaid funds for an array of home and community-based medical assistance services provided to eligible recipients as an alternative to institutional care. Since July 1, 1987, the State of Utah has provided Medicaid-reimbursed home and community-based waiver services for individuals with developmental disabilities and mental retardation. The approval includes waivers of:

* the "comparability" requirements in subsection 1902(a)(10)(B) of the Social Security Act, and

* the institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act.

Waiver of Comparability

In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the State is permitted to provide covered waiver services to *only a limited number* of eligible individuals who meet the State's criteria for Medicaid reimbursement in an intermediate care facility for the mentally retarded (ICF/MR). "Waiver services" need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a "cost-effective" or a "cost-neutral" alternative to institutional (ICF/MR) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded ICF/MR services.

Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements the State uses more liberal eligibility income and resource calculations when determining recipients' Medicaid eligibility.

1 - 1 Acronyms and Definitions

For purposes of the Home and Community-Based Waiver for Individuals with Developmental Disabilities and Mental Retardation (DD/MR Waiver), the following acronyms and definitions apply:

DD/MR WAIVER Medicaid 1915c HCBS Waiver for Individuals with Developmental Disabilities and Mental Retardation

CMS Centers for Medicare and Medicaid Services

DSPD Division of Services for People with Disabilities

DHCF Division of Health Care Financing

HCBS Home and Community-Based Services

MAR Maximum Allowable Rate

ICF/MR Intermediate care facility for the mentally retarded

1 - 2 CMS Approved Waiver Implementation Plan

The State Implementation Plan for the DD/MR Waiver approved by CMS serves as the State's authority to provide home and community services to the target group under its Medicaid plan. That document and all attachments constitute the terms and conditions of the program.

A. This manual does not contain the full scope of the Waiver Implementation Plan. To understand the full scope and requirements of the DD/MR Waiver program, the State Implementation Plan should be referenced.

B. In the event provisions of this manual are found to be in conflict with the State Implementation Plan, the State Implementation Plan will take precedent.

2 SERVICE AVAILABILITY

Home and community-based waiver services are covered benefits only when provided:

1. To an individual with disabilities who has established eligibility for state matching funds through the Utah Department of Human Services in accordance with UCA 62A-5;

2. To an individual determined to meet the eligibility criteria defined in the CMS approved Waiver Implementation Plan;

3. Pursuant to a written individual service plan.

2 - 1 Eligibility for Waiver Program

A. Home and community-based waiver services are covered benefits only for a limited number of Medicaid eligibles for whom there is a reasonable indication that they might need the services provided in a Medicaid-certified ICF/MR in the near future unless they receive home and community-based services, and for whom, but for the provision of such services, would receive the ICF/MR services, the cost of which would be reimbursed under the Medicaid State Plan.

B. In determining whether the applicant has mental or physical conditions that can only be cared for in a intermediate care facility for the mentally retarded, or the equivalent care provided through the DD/MR Waiver, the individual responsible for assessing level-of-care shall document the following:

1. The individual is Medicaid eligible;

2. The individual's diagnosis of mental retardation/developmental disability is documented by a physician or psychologist's assessment;

3. A qualified waiver support coordinator has documented that the individual meets the level of care requirements specified in R414-502-8: Criteria for Intermediate Care Facility for the Mentally Retarded; and

4. The individual, but for the provision of waiver services would otherwise require placement in an ICF/MR to receive needed services.

C. An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the DD/MR Waiver program.

D. Inpatients of hospitals, nursing facilities, or ICFs/MR are not eligible to receive waiver services (except as specifically permitted for support coordination discharge planning in the 90-day period before their discharge to the DD/MR Waiver).

2 - 2 Applicant Freedom of Choice of ICF/MR or DD/MR Waiver

A. Medicaid recipients who meet the eligibility requirements of the DD/MR Waiver may choose to receive services in an ICF/MR or through the DD/MR Waiver if available capacity exists, to address health, welfare, and safety needs.

B. If no available capacity exists in the DD/MR Waiver, the applicant will be advised in writing that he or she may access services through an ICF/MR or may wait for open capacity to develop in the DD/MR Waiver.

C. If available capacity exists in the DD/MR Waiver, a pre-enrollment screen of health, welfare, and safety needs will be completed by a DD/MR Waiver representative. The applicant will be advised of the preliminary needs identified and given the opportunity to choose to receive services to meet the identified needs through an ICF/MR or the DD/MR Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

D. Once the applicant has chosen to enroll in the DD/MR Waiver and the choice has been documented, subsequent review of choice of program will only be required at the time a substantial change in the individual's condition results in a change in the written individual support plan. It is, however, a DD/MR Waiver participant's option to choose institutional (ICF/MR) care at any time and voluntarily disenroll from the DD/MR Waiver.

2 - 3 DD/MR Waiver Participant Freedom of Choice

A. Upon enrollment in the DD/MR Waiver, the individual, and the individual's legal guardian if applicable, will be given choice among available waiver support coordination agencies. The applicant's choice will be documented in the case record.

B. Upon completion of the comprehensive assessment instrument by the waiver support coordination agency, the individual in participation with the support coordination agency will participate in the development of the individual service plan to address the individual's identified needs.

C. The individual will be given choice of services to meet an identified need if more than one cost-effective option exists.

D. The individual will be given a choice of available qualified providers of waiver services identified in the individual support plan.

E. The waiver support coordination agency will review the contents of the written individual support plan with the individual prior to implementation. The written individual support plan will constitute formal notice of the agency's decision regarding authorized services to be provided to the individual and will include notice of the individual's right to appeal the decision to the State Medicaid Agency. The individual must acknowledge receipt of the notice of decision and right to a fair hearing by signing the individual support plan.

F. Subsequent revision of the individual's individual support plan as a result of annual re-assessment or significant change in the individual's health, welfare, or safety requires proper notice to the individual as described in item E above, plus notice that the individual has the right to select to receive services in a Medicaid ICF/MR in lieu of continued participation in the waiver.

1. A significant change is defined as a major change in the recipient's status that:

   - is not self-limiting;

   - impacts on more than one area of the recipient's health status; and

   - requires interdisciplinary review and/or revision of the individual support plan.

   NOTE A condition is defined as self-limiting when the condition will normally resolve itself without intervention by waiver personnel. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive reassessment.

2. A reassessment is required if significant change is consistently noted in two or more areas of decline, or two or more areas of improvement.

2 - 4 Termination of Home and Community-Based Waiver Services

The Division of Health Care Financing (DHCF) in partnership with the Division of Services for People with Disabilities (DSPD) will compile information on voluntary disenrollments, and routine involuntary disenrollments and will conduct reviews of proposed special circumstance disenrollments from the waiver.

A. Voluntary disenrollments are cases in which participants choose to initiate disenrollment from the waiver. These cases require written notification to the Division of Health Care Financing by the waiver support coordination agencies within 30 days from date of disenrollment. Documentation will be maintained by the waiver support coordination agencies detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process.

B. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from a home and community based waiver program for any one or more of the specific reasons listed below:

1. Participant death;

2. Participant no longer meets financial requirement for Medicaid program eligibility;

3. Participant has moved out of the State of Utah; or

4. Participant whereabouts are unknown.

C. Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by the waiver support coordination agencies within 30 days from dates of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. Documentation will be maintained by the local support coordination agencies detailing the discharge planning activities completed with the waiver participants as part of the disenrollment process.

D. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include the waiver participant no longer meets the corresponding institutional level of care requirements, the participant's health and safety needs cannot be met by the current program's services and supports, or the participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate an individual support plan that meets minimal safety standards.

E. Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:

1. Appropriate movement amongst programs;

2. Effective utilization of program potential;

3. Effective discharge and transition planning;

4. Provision of information, affording participants the opportunity to exercise all rights; and

5. Program quality assurance/quality improvement measures.

F. The special circumstance disenrollment review process will consist of the following activities:

1. The waiver support coordination agency recommending disenrollment will compile information to articulate the disenrollment rationale.

2. The waiver support coordination agency will then submit the information to the state-level program management staff for their review of the documentation of support coordination activities and of the disenrollment recommendation.

3. If state-level program management staff concur with the support coordination recommendation, the case will be forwarded to the DHCF for a final decision.

4. The DHCF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.

5. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

6. The DHCF final disenrollment decision will be communicated to both the support coordination agency and the state-level program management staff in writing.

G. If the disenrollment is approved, the waiver support coordination agency will provide to the individual the required written notification of agency action and right to fair hearing information.

H. The support coordination agency will initiate discharge planning activities sufficient to assure smooth transition to an alternate Medicaid program or to other services.

2 - 5 Fair Hearings

A. The Division of Health Care Financing provides an individual applying for or receiving waiver services an opportunity for a hearing upon written request, if the individual is:

1. Not given the choice of institutional (ICF/MR) care or HCBS waiver services;

2. Denied the waiver provider(s) of choice if more than one provider is available to render the service(s);

3. Denied access to waiver services identified as necessary to prevent institutionalization; or

4. Experiencing a reduction, suspension, or termination of waiver services identified as necessary to prevent institutionalization.

B. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the waiver support coordinator if the individual is denied a choice of institutional or DD/MR Waiver program, found ineligible for the waiver program, denied access to the provider of choice for a covered waiver service, or experiences a reduction, suspension, or termination of waiver services. The Notice of Agency Action delineates the individual's right to appeal the decision.

C. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Health Care Financing may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten calendar days after the date of action.

D. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

E. An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the Division of Health Care Financing. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing, or be conducted concurrent with the formal hearing process.

3 PROVIDER PARTICIPATION

3 - 1 Provider Enrollment

A. Home and community-based waiver services for recipients with Developmental Disabilities and Mental Retardation are covered benefits only when delivered by a provider enrolled with the State Medicaid Agency to provide the services as part of the DD/MR Waiver. In addition to a Medicaid provider agreement, all providers of waiver services must also have a current contract with DHS/DSPD.

B. Any willing provider that meets the qualifications defined in the DD/MR Waiver Implementation Plan, Appendix B-2, Provider Qualifications, may enroll at any time to provide a DD/MR Waiver service by contacting DSPD. DSPD will facilitate completion and submission of the required Medicaid provider application and completion of the required local contract. The provider is only authorized to provide the waiver services specified in Attachment A of the Medicaid provider agreement submitted by the provider.

3 - 2 Provider Reimbursement

A. Providers will be reimbursed according to the specified reimbursement rate(s) contained in the negotiated contract with DSPD.

B. Providers may only claim Medicaid reimbursement for services that are authorized by the responsible waiver support coordination agency. Claims must be consistent with the amount and frequency authorized by the waiver support coordination agency.

3 - 3 Standards of Service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of the Waiver Implementation Plan, and the terms and conditions contained in the DSPD contract.

3 - 4 Provider Rights to a Fair Hearing

The Department provides hearing rights to providers who have had any adverse action taken by the Utah Department of Health, Division of Health Care Financing, or its administrative contractor for the DD/MR Waiver, and who submit a written request for a hearing to the agency. Please refer to Utah Department of Health Administrative Hearing Procedures for Medicaid/UMAP Recipients, Applicants, and Providers in Section 1, Chapter 6 - 14, Administrative Review/Fair Hearing. This includes actions of DSPD or a waiver support coordination agency relating to enrollment as a waiver provider, free choice of available providers by waiver participants, contract reimbursement rates, sanctions or other adverse actions related to provider performance, or improper conduct of the agency in performing delegated waiver responsibilities.

4 SUPPORT COORDINATION

4 - 1 Support Coordinator Qualifications

Qualified support coordinators shall meet the qualifications of a mental retardation professional (QMRP) as specified in the job specifications in the Department of Human Services, Office of Human Resources, or an individual who can meet QMRP requirements within one year of the date of hire, and is under the supervision of a QMRP who approves/signs-off all Level of Care and Individual Support Plan documentation.

4 - 2 Support Coordination Encounters

To better focus primary attention on providing the specific level of support coordination intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual service plan will be the vehicle through which the level of assessed need for support coordination will be detailed in terms of the objectives to be achieved, and the scope, duration, and frequency of intervention to be provided to meet the stated objectives. This approach will also promote support coordinators having specific information about their expected roles and responsibilities on an individualized waiver participant basis. Program performance reviews will assess the accuracy and effectiveness of the link between the determination of need, the service plan, the implementation of support coordination services, and the ongoing evaluation of progress toward the stated objectives.

5 SELF-DIRECTED EMPLOYEE MODEL

A. The self-directed employee model requires the waiver participant to use a Waiver Personal Services Agent as an integral component of the waiver services to assist with managing the employer-related financial responsibilities associated with the self-directed employee model. The Waiver Personal Services Agent is a person or organization that assists the waiver participant and his or her representatives, when appropriate, in performing a number of employer-related tasks, without being considered the common law employer of the service providers. Tasks performed by the Waiver Personal Services Agent include documenting service worker's qualifications, collecting service worker time records, preparing payroll for participants' service workers, and withholding, filing, and depositing federal, state, and local employment taxes.

B. Participant employed service workers complete a time sheet for work performed. The participant confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver Personal Services Agent for processing. The Waiver Personal Services Agent files a claim for reimbursement to the Medicaid MMIS system, through the Department of Human Services USSDS system, completes the employer-related responsibilities, deducts the established administrative fee, and forwards payment directly to the service worker for the services documented on the time sheet.

6 WAIVER COVERED SERVICES RATE SETTING METHODOLOGY

A. The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health, Division of Health Care Financing (DHCF) to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS Waiver program and other applicable Medicaid rules. There are four principal methods used in setting the DHS Maximum Allowable Rate (MAR) level. Each method is designed to determine a fair market rate. The four principle methods are: 1) existing market survey or cost survey of current providers, 2) component cost analysis, 3) comparative analysis, and 4) community price survey.

B. The support coordination covered waiver service provider rate is calculated using the cost survey of current providers methodology in general but includes an added procedure in which each fiscal year the State Medicaid Agency establishes specific cost center parameters to be used in calculating the annual MAR for waiver support coordination.

C. Annual MAR schedules may be held constant or modified with a Cost of Living Adjustment (COLA) for any or all of the waiver covered services in lieu of completing one of the four principle methods depending on the budget allocation approved by the Utah State Legislature for the applicable fiscal year.

D. The State Medicaid Agency will maintain records of changes to the maximum allowable rate (MAR) authorized for each waiver covered service to document the rate setting methodology used to establish the MAR.

7 SERVICE PROCEDURE CODES

The procedure codes listed below are covered by Medicaid under the Home and Community-Based Services Waiver for Individuals with Developmental Disabilities and Mental Retardation.

DD/MR WAIVER CODES/RATES Effective: July 1, 2004			
WAIVER SERVICE	**CODE**	**UNIT OF SERVICE**	**MAXIMUM ALLOWABLE RATE**
Chore services	S5120	15 minutes	$3.74
Chore services – self directed	S5120HR	15 minute	$3.13
Companion services	S5135	15 minute	$3.50
Companion services	S5136	Per day	$72.22
Community living supports, supported living	T2017	15 minute	$5.11
Community living supports, supported living – self-directed	T2017HR	15 minute	$4.28
Community living supports, supported living - adult with parent	T2017EY	15 minute	$4.62
Community living supports, congregate	T2031	Per day	$343.26
Community living supports, intensive	H2016	Per day	$546.20
Community living supports, extended living – child age group	H2021HA	15 minute	$3.52
Community living supports, extended living – adult age group	H2021HB	15 minute	$3.52
Community living supports, host home	S5140	Per day	$343.26
Community living supports, professional parent	S5145	Per day	$343.26
Counseling, individual session	H2019	15 minute	$17.29
Counseling, group session	H2019HQ	15 minute	$5.88
Environmental accessibility adaptation, home	S5165	Per service	$10,000 max
Environmental accessibility adaptation, vehicle	T2039	Per service	$10,000 max
Family assistance & supports, agency based	S5110	15 minute	$4.88
Family assistance & supports, agency based - consultant	S5110HN	15 minute	$8.15
Family assistance & supports, self-directed	T1027	15 minute	$2.87

Habilitation, day – direct only	T2021	15 minute	$3.29
Habilitation, day – administration and direct	T2021TU	15 minute	$7.64
Habilitation, day, individualized	T2020	Per day	$136.37
Habilitation, day, individualized – intensive level	T2020TT	Per day	$304.80
Homemaker services	S5130	15 minute	$3.74
Homemaker services, self-directed	S5130HR	15 minutes	$3.13
Latch key supports, child	T2027	15 minute	$7.96
Latch key supports, adult	S5100	15 minute	$7.96
Personal emergency response systems, purchase	S5160	Each	$225.91
Personal emergency response systems, service fee	S5161	Per month	$38.85
Personal emergency response systems, installation & testing	S5162	Each	$50.00
Respite care, unskilled	S5150	15 minute	$3.26
Respite care, unskilled	S5151	Per day	$82.77
Respite care, overnight camp	T2036	Per week	$365.76
Self-directed supports	H2014	15 minute	$7.62
Specialized medical equipment, service fee	T2028	Per month	$300.00
Specialized medical equipment, purchase	T2029	Each	$10,000.00
Specialized support, diet management	S9449	Per session	$35.84
Specialized supports, massage, chiropractic, acupuncture, communication	T2025	Per session	$53.25
Support coordination	T2022	Per month	$213.40
Supported employment – direct only	T2019	15 minute	$3.29
Supported employment – administration and direct	T2019TU	15 minute	$7.64
Supported employment, enclave	T2018	Per day	$33.49
Supported employment, co-worker support	H2025	15 minute	$1.04
Non-medical transportation, per day	T2002	Per day	$8.93
Non-medical transportation, per mile	S0215	Per mile	$0.36
Non-medical transportation, multi-pass	T2004	Per month	$68.00

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